FORM 2
MEDICAL EVALUATION FOR DRIVER LICENSE MAIL RENEWAL APPLICATION

MONTANA DEPARTMENT OF JUSTICE
DIVISION OF MOTOR VEHICLES
Phone: (406) 444-4590, Fax: (406) 444-7623

Please Return Form To Patient

Name (Last, First, Middle):	Driver License #:	Date of Birth:
Street Address:	City: State: Zip Code:	Daytime Phone #:

INTRODUCTION TO PHYSICIAN:

Montana State Law, Mont. Code Ann. § 61-5-111(3)(d)(ii), requires a medical evaluation form to be completed by a licensed physician.

Pursuant to Montana State Law, Mont. Code Ann. § 61-5-207, **REEXAMINATION OR MEDICAL EVALUATION - WHEN REQUIRED**, a Montana driver license may be denied if it is determined that additional medical evaluation or license testing is required.

Please indicate, to the best of your knowledge, if your patient may have any conditions that could affect the safe operation of a motor vehicle. Complete the sections below and return to patient.

1. IMPAIRMENTS THAT ARE PRESENTLY SHOWN BY YOUR PATIENT:

Yes	No		Yes	No	
☐	☐	Sporadic loss of conscious awareness	☐	☐	Diminished judgement
☐	☐	Loss of consciousness	☐	☐	Memory Loss
☐	☐	Impaired motor functions	☐	☐	Azheimer's disease
☐	☐	Neurological or neuromuscular disease	☐	☐	Confusion
☐	☐	Diminished concentration	☐	☐	Other dementia
☐	☐	Reaction, or impairment due to change in medication or dosage			
☐	☐	Other metabolic disorder			

Comments: _____

_____

2. TO THE BEST OF YOUR KNOWLEDGE, ARE THERE ANY IMPEDIMENTS THAT SUGGEST YOUR PATIENT MAY HAVE A PROBLEM DRIVING A MOTOR VEHICLE?

Yes No

☐ ☐ If yes, please describe: _____

_____

3. DO YOU RECOMMEND ANY DRIVING RESTRICTION OR ADAPTIVE EQUIPMENT TO ASSIST YOUR PATIENT WITH OPERATING A MOTOR VEHICLE?

Yes No

☐ ☐ If yes, please describe: _____

_____

LICENSED PHYSICIAN/PROVIDER:

Signature:	Name (printed):	Date:
Type of Practice: Medical License#:	Address (include city, state, & zip):	Phone #: